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ABSTRACT

For the past eight years an unusual treatment program for drug-addicted youth has evolved in Copenhagen, based on voluntary participation and focusing on social and emotional rehabilitation. The program evolved through trial and error, with elements in the system coming at the suggestion of youth. This report reviews the evolution and describes the present system and its results. There are a number of principles of this program which have important implications for programs in America: (1) the program is voluntary; (2) the client is involved in planning his own treatment program; (3) the emphasis of the program is on changing the life style of the client; (4) the central therapeutic agent is a peer with whom the young addict can identify; (5) the system evolves gradually and is flexible; (6) the young addict is removed from the complex, urban life to a more simple, rural society and reenters urban society on a very gradual basis. (Author)

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A TREATMENT PROGRAM FOR

DRUG ADDICTED YOUTH IN DENMARK

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For the past eight years an unusual program of treatment for drug-addicted youth has evolved in Copenhagen, based on voluntary participation and focusing on social and emotional rehabilitation. The evolution of the program was through trial and error, with, as will be seen, elements in the system coming at the suggestion of the youth. This report will review this evolution and describe the present system and its results.

Early History

In 1960 a Youth Clinic was established in Copenhagen, financed by the Ford Foundation, for the study of juvenile delinquency. In 1965 the study had been completed and the Youth Clinic was due to close. At this time, however, there was the beginning appearance in Copenhagen of a new phenomenon: young persons differing in their ap pearance, behavior and attitudes from those seen previously. They had long hair, were often barefoot and dirty, and wore unusual, extravagant clothing. They smoked cannabis, took LSD and perhaps other euphoric drugs; many had abandoned their homes and educations to live in slum buildings under miserable conditions. Some of them were influenced by the Provo movement from the Netherlands and the U.S. hippies.

Because of the appearance of this new group, it was decided that the Youth Clinic should remain and attempt to assist this group. The administration of the Clinic was taken over by the Danish Association of Mental Health; 90% of the expenses were provided by the government and 10% by the Association.

The Youth Clinic was, at this time, providing more or less traditional psychotherapy on an individual or small group basis in its clinic building. The staff now began to go out into the streets to the places frequented by this new group to learn more about them as the group was not, of course, coming to the Clinic. By 1967 it was clear that the more traditional approaches and facilities were not effective. During a two month period in 1967 "open house" was held weekly in a borrowed Youth Club where the Clinic staff could get insight into the views of this special group of youth.

On the basis of what had been learned, a special, confidential report was submitted to the government in 1968 which proposed more untraditional forms of treatment for young drug abusers. In addition to the Youth Clinic, a Contact Center open during the day and a hostel or youth collective were suggested. Group therapy was proposed as the chief form of therapy. The personnel were to be composed of professional staff and of "medarbejders" (co-workers)--students or young persons, including ex-addicts, without professional training. The report was accepted by the government and in 1969 the new program, based on the proposal, was started with 4/7 of the funds from the central government and 3/7 from the City of Copenhagen.

Program Evolution

Since 1969 the program has gradually evolved and expanded to the present system to be described later. It is not

possible in this report to detail all the facets of this growth but several examples will be given to illustrate how trial and error, staff participation and consumer participation were involved in the evolution.

Perhaps the best example of trial and error is the story of the Contact Center. As originally conceived in the 1968 report, this was to be a place where, during the day, youth on drugs could drop in to talk with medarbejders, eat, listen to music and relax. No formal program was to be given and no drugs would be allowed. It was expected that the medarbejders would gradually interest youth in applying to the Youth Clinic for help. A brochure "What's happening at the Contact Center" was placed in the Center.

What happened? No one ever read the brochure and it disappeared. The Center filled with youth on drugs who stayed the whole day and lay around with no activity and smoked hash. Huge amounts of food were consumed. Vandalism, theft and destruction soon became a serious problem. Both the medarbejders and the youth on drugs resented the fact that they were not involved in the planning meetings held at the Clinic. And finally, in spite of all efforts, it was impossible to keep drugs out of the Contact Center.

What was done? First, the medarbejders and the drug addicts were invited to the planning meetings and became regular participants. Next, something had to be done about the lack of organization, structure and content of the program in the Center. The medarbejders in the Center had, partly for ideological reasons, partly because of understandable uncertainty, taken a passive role, since they did not want to force the clients in a particular direction but preferred to wait for them to take the initiative, after which they would help and support them. But the clients were so concerned with durgs that they were interested in little else and

were quite passive and without initiative. Gradually the staff at the Contact Center had to change their attitudes and their role. They learned that they must no longer wait to back up the clients but take the lead and initiative and be active. The work at the Center became more organized with better control over the food situation; cleaning became more orderly and the first beginnings were made in the production of leatherware and other crafts.

Another important change in the Contact Center was the hours of operation. The Center had become the only stable environment for the young addicts. Closing at night threw them back into their previous milieu. Gradually they were allowed to spend the evenings and then the nights in the Center. Since there was no staff at night, however, many of the clients would sleep all day at the Center and be awake at night after the staff left. This problem was solved by adding a night staff--a very important addition to the program.

A final problem facing the Contact Center was the issue of bringing drugs into the Center. During the first half year of operation every attempt was made to insure no drugs were brought into the Center. Gradually the staff faced the fact that this was an illusion. It was naive to assume that young people who had been taking drugs daily over several years would stop simply by going through a door. It had to be recognized that the most affected group of drug abusers, which included the majority of those coming to the Center, could not give up drugs immediately. So it was decided to accept that drugs were taken in the Center. On the other hand, it was not necessary to accept the sale of drugs, although it was recognized that it occurred in spite of everything.

What has evolved, then, as a Contact Center? It has become a place to establish contact with young drug abusers

and to gradually motivate them to break free of their abuse. Genuine therapy or reduction in drug consumption can not take place here. The Center can satisfy the basic needs of the clients--food, sleep, warmth--and they can become involved in discussions, crafts, music, etc. And they can become acquainted with the therapeutic program to be described later.

The vital role which consumer (i.e. drug addicted youth) participation plays in the evolution of this drug treatment program is clearly illustrated by the unusual story of the "discovery" of the detoxification tour--now a vital element in the treatment system. The 1968 report suggested that, in addition to the existing Youth Clinic, a Contact Center and a Hostel should be established. The purpose of the Hostel was to provide a place where youth, who were now free of drug abuse, could live together while making some definite plans for their future. As with the Contact Center, the Hostel had a rather stormy beginning. The 22 resident clients together with the resident medarbejders were responsible for setting house rules and insuring smooth cooperative living. Such issues as the length of time guests could be allowed to stay became most difficult. The majority of resident clients were in favor of deciding for themselves how many and how long their friends could live there. If one has one's own room, where, in the client's opinion, seven or eight additional people could sleep, it seemed unreasonable not to help one's friends when they didn't have a place to live. The leaders of the project were strongly against this as it would be impossible to control and it would not be long before 100 people would be living there. This, and other issues, were gradually resolved and for a period of time the Hostel functioned smoothly.

Then it was discovered that a group of 6 hostel residents had again begun to inject drugs. The problem was discussed at a hostel "house meeting" and it was obvious that one of the group of offenders was the leader and had considerable influence over the other five. So the hostel residents decided that this leading offender would be given 14 days to find another place to live.

After the house meeting, the 5 offenders (not including the offender's leader) got together to try to figure out what they could do to help their evicted friend. They decided to ask the consultant psychiatrist at the Youth Clinic to meet with them. The psychiatrist agreed. At the meeting the 6 offenders (now joined with their leader) first admitted their renewed drug abuse. They then offered a proposition to the psychiatrist: the offenders would go to an isolated "retreat" in the countryside for 14 days, accompanied by two medarbejders with whom they felt especially close, to see if they could give up their drug abuse. If they could, then <u>all</u> of them would be free to return to the Hostel if they wished. The psychiatrist relayed this proposal to the Hostel residents and to the project staff and everyone agreed to it. The offenders succeded in withdrawing from their drugs while on the two week tour and returned to the Hostel. (Ironically, the offender's leader chose, rather, to go to his own home to live and has since managed well.)

Six months later another group of 6 Hostel residents were found to be abusing drugs. Because of the dramatic success of the previous consumer-conceived withdrawal tour, this group of offenders was given the choice of moving out of the Hostel or going on a similar withdrawal tour. They accepted the latter offer and all managed to give up drugs on the tour. At the end of the tour, however, these clients were reluctant to return to Copenhagen. They did not feel

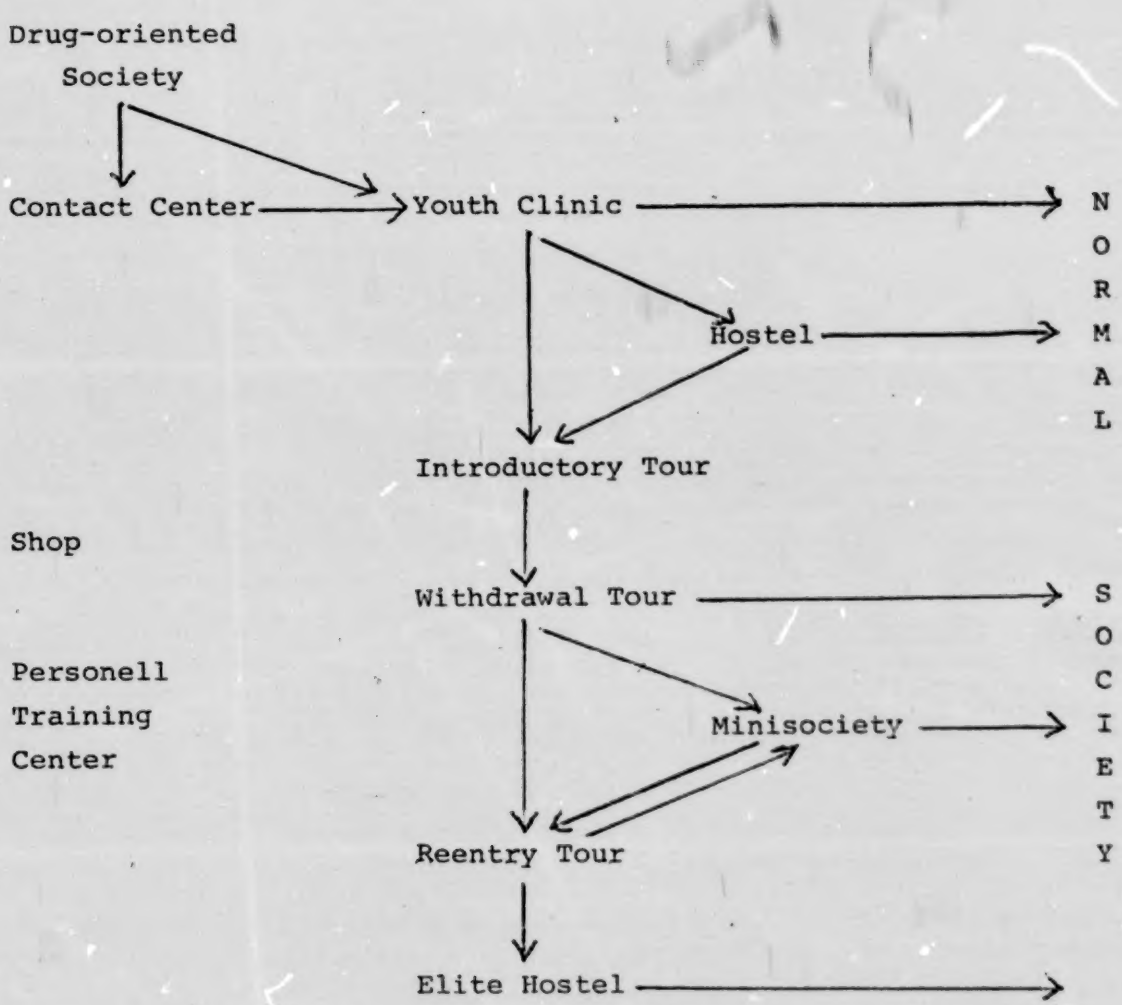
ready to cope with the stresses and temptations found there and asked if the project would allow them and their two medarbejders to stay longer. The project staff agreed and another house was rented on a small island. Here the group lived for a number of weeks. In order to fill their time with constructive activity, they began to make leather clothing, bags and belts. They found they could sell them and, in fact, began to support themselves with this activity. And so the "reentry tour" and the "shop"--two further important elements in the present system--were born, both consumer-conceived and consumer tried.

Present System

Although the program continues to evolve today, a basic overall scheme has developed, illustrated on the following page (page 8).

The first, and most important, principle of the scheme is that it provides a bridge in assisting youth in moving from their drug-oriented society back into normal society. As stated by Dr. Karen Berntsen, the Director of the program: "It was felt that a large number of the young drug addicts suffered from contact difficulties with their primary groups, isolation from their contemporaries, immaturity, oversensitivity, and an extraordinary low level of frustration, so that they could not cope with even minor opposition. The drugs became their means of escape from adversity and frustration, and at the same time the drug culture and drugs gave them a false sense of security and a pseudo sense of belonging. Any treatment program would have to take these elements into consideration in finding alternatives to the effects of drugs and the drug culture." The treatment bridge lasts only as

Treatment System Scheme



long as is necessary. Thus an individual may come to the Contact Center or the Youth Clinic, stay only a few weeks and reenter normal society. On the other hand he or she may find it necessary to remain in the protective environment of the program for many months or several years before feeling strong enough for full time involvement in normal society. This latter person would move down through the various elements of the treatment system according to individual need.

In order to best understand this first principle, it is important for the reader to appreciate the broadened definition of "normal society" used by the program. Again quoting Dr. Berntsen: "Another important aspect of the program is the idea that less emphasis is placed on the re-socialization process in the ordinary sense of the term than has been the case in previous measures, which attempted to get the young people to function as quickly as possible occupationally and socially at the same level as the majority of young persons and adults in the existing society. Greater consideration is given to the idea that society is in many ways undergoing great change, which may mean that the values and norms which the older generation has grown up with are being replaced by other values and norms. The goal of the treatment program is thus to get the young persons to give up drugs by finding a life form which is more satisfying to them and less of a burden for society."

In crossing over the bridge to this more satisfying life style, the client is helped by another guiding principle of the program--don't preach against drugs (in fact, don't talk about them at all)--but talk rather about life and in this way shift the client's focus of time and energy from drugs to the process of maturation and living. This principle is explained by the Director: "When we at the Youth Clinic began

to concern ourselves with drug abusers, we made the assumption that drugs in themselves were of minor interest to our work. Whether our young clients used one or another drug, how much they used, how often, were not the important questions. The drugs had to be considered as symptoms. The most important thing was to delve behind the symptoms and, to the best of our ability, to discover the factors which contributed to drug abuse. We consciously attempted to avoid long discussions about drugs, as it was our experience that the young drug abusers were so concentrated upon the drugs themselves, on obtaining them, taking them, trying new ones, talking about them, that their lives revolved around drugs. Therefore, we agreed that one of our tasks was to get them away from their drug ideology and this could hardly be acheived by encouraging a continuation of this discussion."

Another important principle of the therapeutic scheme is to provide continuity of supervision during the treatment. Each client has his or her own medarbejder who supervises the treatment throughout. This has presented many difficulties because elements in the system--the Hostel, Contact Center, Youth Clinic--have seperate staffs. In spite of this, the overall guidance of each client by his own medarbejder has been maintained.

Having the same medarbejder throughout is considered important because one of the cornerstones of the treatment program is the socio-psychological phenomenon--modeling. By providing a consistent "model" who is also young, also "with it" with regard to the youth culture of today (and who may have also have been on drugs), but who seems to have found a more satisfying life style, the young drug addict is at once given hope and motivation for change. This same principle of modeling is the basis for having most clients

move through the system in small groups of four to six. In this way they come to know each other intimately and can, alternately, serve as models for each other if one member of the group is in a crisis.

Each of the elements of the system will now be described:

Contact Center

Many aspects of the Contact Center were described previously. There is a register at the Center where everyone, including staff, guests, and clients, write their name and time of arrival and departure. Although the register has never been 100% complete, it has been of inestimable value in later reports.

There is a regular turnover of clients in the Center. As the youth come in contact with the Clinic and move into other elements in the program, they no longer need the Center. As the Center program evolved it was decided to put a time limit on using the Center. Those clients who, after three months at the Center, show that they are not interested in altering their situation and do not wish to avail themselves of the other parts of the program can no longer use the Center. If at a later time they find their situation intolerable, they may return and accept the offer for the program.

The number of clients at the Contact Center each day varies from 10 to 40 young people with an average of 25. There is room for about 14 people to sleep at night. After a client has visited the Center several times, a staff worker will suggest he go to the Youth Clinic. Approximately half of those coming to the Center eventually go to the Clinic for help.

Youth Clinic

The Youth Clinic serves two purposes: it is the headquarters for the overall program and is the outpatient treatment facility. The headquarters houses the professional staff including the Director and Assistant Director, both clinical psychologists, a social worker, a psychiatric consultant, a medical consultant, and a sociologist consultant. Here the planning meetings and staff meetings are held and the administration of the overall program takes place including recruitment of new workers, coordination with other community services, preparation of reports, etc.

In serving as the outpatient treatment facility for the program, the Youth Clinic houses a staff of medarbejders. Each medarbejder has an office where he can meet with clients on an individual basis. In working with clients, the medarbejders are backed up by the team of professionals who are located in the same building. With the aid of this professional assistance, the medarbejder and his client plan the program of treatment for the client. The main type of therapy at the Youth Clinic, as mentioned preniously, is group therapy.

Hostel

The Hostel was briefly described previously. It is a place where 22 ex-addicts and 6 medarbejders live. It serves as a half-way house for these clients who have succeeded in giving up drugs and who wish to live in the city but who still feel the need for supportive services and a supportive environment. In addition to frequently meeting with their

medarbejders, there is also a consultant psychologist for them to call on. In addition to house meetings there is also group therapy, psychodrama and other therapeutic measures at the Hostel. A workshop is located in the building where, if they are not otherwise employed, they may work during the day making crafts.

Residents may stay as long as they wish--from a few weeks to over a year--if they remain off drugs and make use of the Hostel programs. The rent is 25 Danish Kroner ($4.50) a week. If they are not employed or making sufficient money from workshop products, the rent is deducted from their unemployment check. The residents must provide their own food although common breakfasts and evening meals are available for a fee to increase contact between residents and staff.

Over 80% of those who have lived at the Hostel were previously injecting hard drugs. A follow-up study reveals that 60% of the girls and 76% of the boys show a positive result in that they have remained off drugs and are either employed or continuing their education.

Introductory Tour

Originally clients at the Contact Center, Youth Clinic or Hostel were sent directly to a withdrawal tour. This presented a number of problems: sometimes the group of clients was not compatible; sometimes a client was not ready for withdrawal and ran away. Because of these and other problems the introductory tour was conceived and has proven to improve if not solve most of the problems. The group of 6 to 8 clients and their medarbejders move to a special house in Copenhagen for a period of 8 days, during which time the clients receive maintenance doses of methadone twice a day.

It is determined whether the group can cohere and whether the clients can refrain from their search for daily doses of drugs. The clients cannot leave the building except with a medarbejder and must submit to searches for hidden drugs. During this period the necessary medical examinations and laboratory tests are performed. Various therapeutic techniques including group therapy, psychodrama and methods of relaxation are introduced and attempts are made to invite parents and other concerned persons to participate in group discussions. After the 8 days have passed those clients who have shown themselves to be compatible and ready for withdrawal leave together with their medarbejders for the countryside and the withdrawal tour.

Withdrawal Tour

The origin of this element of the program has been described. The basic idea behind the tour is to remove the clients from their drug-infested environment and place them in a small, rural, carefully monitored therapeutic environment which is as free and normal as possible. Here they are withdrawn from the drugs as quickly as possible and in a way that permits them to experience the withdrawal symptoms, although these are held to within tolerable limits. They participate in planning their own cure and are, in part, responsible for it. Detoxification occurs within groups of 4 to 6 persons who are to support one another with the close aid and support of two medarbejders. At any time they can interrupt the cure by leaving the group, but it is up to the other group members whether they may return.

The 4 to 6 clients and 2 medarbejders leave for a somewhat isolated house in the countryside where they will live together for 8 weeks. The first 2 weeks of the tour

are occupied with the methadone-assisted withdrawal therapy. During this period of extreme stress the medarbejders must stay close to and be supportive of their clients 24 hours a day. All physicians and pharmacists within 10 kilometers are given the names of the clients and medarbejders and will not prescribe for the clients without the approval of the psychiatric consultant in Copenhagen. The psychiatrist from Copenhagen visits the group a couple of times during the withdrawal phase and again when it is over. It is sometimes necessary to call the local physician if there are particularly serious episodes. It must be expected that one or two members of the group will give up and drop out during the first two weeks.

Once the drugs have been withdrawn, however, the work is only beginning. The next phase is called the physical rehabilitation phase, and lasts about 3 weeks. The young drug abusers are often malnourished and have one or more physical problems which were disguised as long as they were on drugs. Most of the cases can be treated by providing rest, quiet and a nourishing diet. Restoring physical well-being is important so that physical complaints will not contribute to resumption of drug abuse.

Gradually the clients, then, begin to take an interest in their environment and the first steps may be taken toward functioning in society. The clients begin to participate in ordinary life, accepting responsibility for the group's well-being and accepting more tasks in the daily routine. Contacts may be established with neighbors and recreational activities appear, including craft work.

The original withdrawal tour was 2 weeks in length. Then a 3 week period of rest and rehabilitation was added.

This proved to be insufficient and the tours now last 8 weeks. In one sense the entire tour is a group therapy experience as the small group learns to live without drugs, leaning heavily on their medarbejder models.

One variation of the withdrawal tour should be mentioned--the individual tour. Some of the drug addicts are so physically and psychologically debilitated and so eccentric in their behavior that they cannot integrate in a group. In such cases, arrangements have been made for a tour in which the client is alone with a medarbejder. As this is a very expensive measure and is extremely demanding for the medarbejder, it is reserved for selected cases.

Minisociety

The minisociety program is still considered to be in the experimental stage. A number of minisocieties have been held, often with different mixes of clients from different stages of treatment. Nevertheless the basic concept is the same: a group of clients and a group of "helpers" live together for 2 weeks in an isolated setting. There are, at the start, absolutely no rules for living. The total group must evolve a new society by establishing rules of living which they feel are satisfactory and by which they are willing to live. Thus it is an experience in learning what society is all about and why and how society must establish rules. The individual learns about the interaction between individual freedom and group needs and goals.

The minisociety usually has 30 to 40 members. Approximately one-third of the members are staff, both medarbejders and professionals, and two-thirds are clients. Clients are always drawn from several different sources for each

minisociety and may include: groups just completing a withdrawal tour; groups from reentry tours; a group-therapy group from the Youth Clinic; individuals from the Youth Clinic or Hostel; and most recently a group of alcoholics. The members of the minisociety live in small houses holding 4 to 6 persons (family groups). Each house is provided with funds for housekeeping and must purchase and prepare its own food. Each house must establish its own rules of living. In addition all groups of the minisociety meet together daily to establish the rules and activities for the whole minisociety. In all of these meetings the clients have equal status with the helpers. In fact, one of the important concepts underlying the minisociety is that "we all have problems--some of us have taken drugs and some of us have a big need to help others".

In the process of working out their new mini-minisociety, family groups often become, essentially, marathon therapy groups. In the process of working out the total-group new minisociety many different techniques are tried including dramatization, dancing, group games, etc.

The minisociety has proven to be an exciting innovation in the program. One of the authors attended a 2 week minisociety as a participant-observer and was most impressed with its educational and therapeutic value. It appears to be particularly effective for clients who have just finished the withdrawal tour or the reentry tour.

Reentry Tour

At the start of a withdrawal tour the group of clients have a common goal--escape from drugs. For a while they are acheiving success in this and are also united in learning to know one another and in learning to live together. By

the end of the withdrawal tour, however, they discover that they may be quite different from one another with such completely different ambitions, abilities and interests that their association is artificial and they begin to be impatient, bored and argumentative. At the conclusion of the withdrawal tour some individuals are strong enough to return to Copenhagen and to support themselves. The majority, however, are not ready to return at this time and should keep out of Copenhagen until they have a chance to strengthen their personalities, to gain greater self-insight, to become more adept at coping with adverse situations and to find out what they want to do with their future. It is for this group that the reentry tour is designed.

The reentry tour consists of 10 to 12 clients and their medarbejders living together for two to three months in a semi-isolated environment. They participate in socio-psychological techniques including sociodrama, psychodrama, role-playing, and group therapy; and also in educational programs so that their self-confidence is increased by more information and knowledge. Occupational therapists and rehabilitation experts frequently consult in these programs. The making of craft objects is nearly always an important part of the therapeutic program.

The semi-isolated environment of the reentry tours has taken a number of different forms. The majority of the reentry tours have been at farms in the Danish countryside purchased or rented by the program. Tours have also taken place in foreign countries--Sweden, Norway, rural Southern France and the island of Rhodos off Greece, for example. A sailing schooner has been chartered and the tour has taken place on board while sailing the waters around Scandinavia.

One of the purposes of the reentry tour is the gradual

reintroduction of clients into society-at-large, starting at the less complex rural level. The drug abusers and even the medarbejders are often at first regarded by the residents of the area with suspicion and skepticism; their appearance and dress are exotic and attract attention in the surrounding villages. Gradually, as the inhabitants become accustomed to them and learn to know them, attitudes quite often change and their reservation and rejection may change into a positive interest and participation in the life of the group.

At the end of the reentry tour each client, with the aid of his medarbejder and perhaps also professional consultants, must plan what his next step shall be. Most clients are now ready to return to Copenhagen, either to their own homes, or to the Elite Hostel or other living groups or arrangements. A few choose to remain in a rural setting, as for example one group who established a rural collective. The clients are also helped in deciding on their educational and/or occupational plans. In any case, many of the clients will maintain contact with the program through their medarbejders and the Youth Clinic.

At present the reentry tour is considered a vital part of the overall treatment scheme. It is the place where the clients may develop wider outside interests, learn to know other people, discover new values, become aware of their own opportunities, abilities and interests and have a chance to determine how they are to employ these.

Elite Hostel

The purpose of the Elite Hostel is to provide a place for a group of ex-addicts to live for a while in a setting in which they can both test their powers by being in contact with normal society through education and employment and also have a protective environment with communal living, collective

responsibility and leisure time activities. The Elite Hostel is located in a non-drug infested area of Copenhagen. There is room for 12 residents. In addition there are "Club" facilities, where 20 to 30 other drug-free clients who live elsewhere may come each day in the afternoon and evening to spend their free time so as to reduce the temptation to return to their old drug groups. The Club includes: a kitchen where the clients can buy, prepare and eat their evening meal; a coffee room for discussions and quiet get-togethers; and various workshop activities.

Among the group at the Elite Hostel are occasionally found ex-addicts with both the desire and ability to work with new drug abusers. These individuals may be trained as medarbejders during their residence in the Elite Hostel.

Shop

As the production of handicrafts became an important part of the programs at the Contact Center, Hostels and Tours it was decided to see if it might be possible to market these products. The first purpose of handicrafts is a therapeutic one in helping to overcome passivity by having clients involved in meaningful work. It was felt, however, that it would be both more valuable and more encouraging if the things that were produced were also sold. This would be better than mere hobby projects and would also allow clients to earn money.

An empty store front was rented which is near the Youth Clinic, Contact Center and Hostel. Two university students were hired to operate the shop as it was thought that the clients would not be able to exclude the sale of drugs or keep regular hours and the necessary bookkeeping.

The variety of crafts produced and the high quality of

the work delivered to the Shop is exceptional. Clients are paid half of their earnings when the Shop accepts their goods and the other half when the goods are sold. Sales from the Shop have increased rapidly necessitating expansion of both space and personnel.

Personnel Training Center

The program has rented a facility outside of Copenhagen where up to 25 persons can stay. Newly recruited staff (including ex-addicts) attend a training course here for a week before beginning their work. The facility is also used by groups of staff who have completed various tours. They come together here for several days to exchange experiences, support and help one another and learn from each other. The program also uses the facility for seminars.

Clients

A research project under the direction of the Mental Health Research Institute of Denmark has been closely connected with the therapeutic program. A section of this research project has compiled data on each client. The data is not 100% complete, partly because contact with some clients has been so short or so sporatic. The only data on the clients which, to the present time, has been analyzed is an analysis of all clients who came in contact with the program in 1969. Although this was one of the earlier years of the program, the results should, in general, reflect the present charactaristics of the clients. A brief summary of this data follows.

How do the clients get involved in the program? Of the 382 clients seen at the Youth Clinic in 1969, 97 (25%) came

from the Contact Center and 88 (23%) came on their own initiative--thus 48% or nearly half were, in fact, self referred. Only 39 (10%) were referred by parents or relatives. The remaining 42% were referred by community agencies including child welfare authorities 25%, hospitals and doctors 5%, youth clubs 4%, schools 3%.

67% of the clients were boys and 33% girls. The age range was 12 to 27 years (the official range is 14 to 18 years but the program has chosen not to turn away clients in need). 15% of the clients were 15 years of age or less; 66% were between 16 and 19 years old. The girls were somewhat younger than the boys.

Background factors on the clients seen in 1969 are as follows. 58% came from broken homes and only 23% came from an unbroken home with no known pathology. The intelligence curve is skewed for clients with only 4% retarded but 22% gifted. 45% of the clients have had school problems. 38% have been in institutions at least once (child welfare homes, jail, reform school). It might be noted here that escape from an institution has often been a direct cause of young people's application to the Youth Clinic after having tired of wandering around Copenhagen trying to evade the authorities. These people are given a choice: they may allow the Clinic to contact the institution or they may freely leave but not return. In most cases the institution will allow the person to remain in Copenhagen if the Youth Clinic accepts further responsibility.

42% of the clients had at some past time been admitted to a psychiatric unit and/or mental hospital. Almost half had been admitted more than once and some many times. This is because the clients leave or are told to leave because they will not conform to the hospital rules. When they came to the program, 45% of the clients did not have a fixed residence and

only 27% had work or were in school.

Parent Contact

So far as is possible, the Youth Clinic has tried to establish contact with the parents if the child is under 18 years of age, and in some cases also with the parents of older clients. The staff has had personal contact with parents in 43% of cases and telephone contact in an additional 13% of cases. The contacts have, for the most part, consisted of meetings with the parents at the Youth Clinic.

Parent contact has, in many cases, limited value as expressed by the program Director: "We have always remembered that it is the young person who is most important in our work and furthermore that we are working with a group of persons who have reached an age at which they are or should be in the process of creating an independent existence for themselves. If the relations within the family are too disturbed, it is not likely that it would benefit the young person to encourage him or her to think that a family situation which may have contributed to the present disturbed condition can now be coped with. Perhaps the relationship may be renewed at a later time when the client has developed more and has achieved greater maturity, this permitting a more realistic relationship with the parents."

Results

Early in 1970, all clients who had been in the program in 1969 were evaluated to determine what, if any, effect the program had had on their condition. The evaluation included not only their drug usage but also their education/employment

status and their level of personal adjustment. This evaluation showed:

1) No effect of treatment 17%
2) Some effect of treatment, especially in extent of drug abuse but still many problems. 14%
3) Greatly reduced or discontinued drug abuse and socially acceptable life situation 31%
4) Other measures provided or recommended (return to home or institution, referred to hospitals, etc.) 24%
5) Information unavailable (clients can't be found) 14%

If one combines group 2 and 3, then 45% of the clients had shown beginning or definite improvement.

Analysis of these results by sex shows more boys with no effect of treatment (22% versus 9%) and more girls with some effect of treatment (17% versus 12%). An equal percentage of girls and boys were in catagory 3 (marked improvement). Boys who abuse drugs by using injections are the most difficult group to treat.

One other analysis of results is by length of stay in the program. As might be expected, there is a positive correlation between longer treatment period and greater improvement in condition. If one is familiar with results acheived in other drug abuse treatment programs, it is rather startling to find that the most serious drug abusers who have maintained contact with the system have acheived a beneficial effect from treatment in 60% of the cases.

Problems

The first problem is one not unique to this Danish program but to nearly all service programs in Denmark: a weakness with program evaluation. As we have stated in most of our earlier reports on the child care system in Denmark, the emphasis is on the empirical trial and error approach to services. It is most difficult in Denmark to secure funding for ongoing program evaluation. In this regard, the present program is stronger than most but, to American eyes, could be strengthened even more.

A second problem has plagued the program from the beginning and remains a difficult dilemma. This is conflicts among the staff. The first, and most persistent, conflict is between the professional leadership of the program and the large staff of medarbejders. The medarbejders are young, dedicated, conscientious and idealistic and wish, rightly so, to have a stake in the evolution of the program. At the same time the professional leaders are ultimately held responsible for everything that happens in the program and so feel it is essential that they have the final say. A system has been worked out whereby each unit in the program choses one or two delegates who meet with the leaders (Director and Assistant Director) each week. Every other week the meeting is for the purpose of supplying reports and gathering information; on alternate weeks decisions are made. In this way, the representatives have an opportunity to report suggestions made at one meeting to their colleagues before the decision is made at the following meeting. Decisions are made unanimously among the delegates without voting, which means in fact that each delegate has the right of veto. This right of veto has not, up to now, been

actually exercised, although the leaders have at a couple of meetings stated that they would use this right if particular suggestions are proposed. Many disagreements have been thrashed out but the basic conflict between these two groups remains.

There have also been conflicts among the groups of medarbejders from different elements in the system. The system of delegate meetings has improved these conflicts considerably.

A third problem is the confusion, if not chaos, which has occasionally developed as a result of allowing the program to evolve slowly on a trial and error basis. (The situation described at the Contact Center in its early days is an example.) In retrospect, the leaders feel that this problem is a necessary evil--the staff can wholeheartedly accept new ideas and a certain structure only as a result of periods of chaos and disorganization.

A fourth problem is somewhat more mundane--where to locate program facilities. People, in general, are afraid of addicts, feeling they are a bad element which might infect others in the neighborhood. In addition, the addict's life style can be hard to live with or near. An example was a conflict that arose between the Contact Center and the neighborhood residents who complained to the authorities and the newspaper about the dirt, noise (especially at night), discarding of hypodermic needles, etc. A meeting at the Contact Center was held, attended by shopowners and residents in the neighborhood, the press, several local civil servants, the Mayor of Copenhagen, Center staff and clients, and the program leaders. Some of the complaints were justified, some were outdated and some expressions of opinion seemed more a statement of uncertainty in the face of a new and unknown phenomenon. The meeting was a success, in part because of

the reaction of the press. Nevertheless care must be taken in locating new program facilities and in building good relations in the neighborhood.

A final problem is perhaps the most crucial: convincing the society-at-large that such a program is worthwhile. One of the goals of the program is for the clients to stop taking drugs but this is, of course, only a symptomatic cure. For the clients to change their life style is a slow, long, difficult process. Furthermore it is expensive (requiring lots of staff) and it is most difficult to measure--much less prove. In addition, in a program such as this it is the failures which tend to attract notoriety, not the successes. Several clients have died, either while in the program or after leaving and, of course, this is the stuff of headlines. And, unfortunately, Denmark is not without that conservative element of society which insists that young drug abusers should be punished--not "given a paid vacation!"

This problem must always be kept in mind by the leaders and, on occasion has necessitated a program change. The tours to the South of France, for example, had to be cancelled because of a bad press and public reaction. At the present time, however, the program is, in general, favorably supported by the community and by the government.

Implications for the United States

The United States has a most serious problem with young drug abusers. We believe that the best approach is to try many different methods or systems of treatment. The program in Copenhagen has acheived an unusual degree of success. A physician from the United States specializing in this problem recently visited a number of European countries under the auspices of the World Health Organization and concluded that

the program described in this report was by far the most successful. There are a number of principles of this program which have important implications for programs in America:

1) The program is entirely voluntary and the young drug abuser knows he is free to leave at any time.

2) The client is very much involved in planning his own treatment program and in being responsible for it. In addition the clients may, at times, also help to plan the overall program.

3) The emphasis of the program is not on drugs--yes or no--but rather on changing the life style of the client to a more satisfying one in which drugs will become superfluous if not an anathema.

4) The central therapeutic agent in the program is a peer with whom the young addict can identify and whom he can model. These medarbejders (co-workers) are intimately involved in the ongoing evolution and management of the program.

5) The system evolves gradually on a trial and error basis. New ideas may come from anyone and the program must be flexible enough to allow for these ideas to be tried.

6) Perhaps the most innovative principle has been that of removing the young drug addict from the complex, drug infested urban life to a highly supportive, simple, rural, small new society. After withdrawal, the ex-addict gradually reenters normal society, only when he is ready and only at a level of which he is capable.